STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155152	A. BUILDING **01** B. WING _____	R **07/25/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	**1120 N MAIN ST** **MONTICELLO, IN 47960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/26/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/25/16 Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440 At this PSR survey, Monticello Healthcare was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility is located in a fully sprinklered facility of Type V (000) construction and was fully sprinklered with a partial basement and on the first floor of a two story building determined to be Type V (111). The facility was surveyed as two buildings due to different construction Types. The facility has a fire alarm system with hard wired smoke detection in the basement, corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 116 and had a census of 90 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered except	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 for the a detached shed and building used for facility storage which were not sprinklered. Quality Review completed on 07/28/16 - DA	{K 000}		